Appendix A-V. Data Sources, Assumptions and Methodologies

Purpose of this Section

This appendix section provides additional data for the Findings Section from the Community Impact Analysis (V. Impacts on Availability, Accessibility and Affordability). It includes:

- **Sources** – Sources for data, quotes, and other facts are cited.
- **Assumptions** – Any assumptions used when gathering or processing data.
- **Methodologies** – The approach used when processing data and driving findings.

Organization of this Section

This appendix is organized in the following sections:

A. Business Purpose and Foundations
B. Competition
C. Availability and Accessibility of Doctors and Hospitals
D. Medical Management Policies and Practices
E. Operations
F. Products
G. Pricing
H. Governance
I. Regulation

Linking this section with section V. of the Community Impact Analysis

The reader can cross reference the Community Impact Analysis by noting the superscript indices. For example this sentence from the community Impact Analysis:

> "On a per capita basis, the PBO foundations, considered together across Maryland, Delaware and Washington, D.C. would be the largest ever created, based on the conversion of a Blues plan, in any state[A.7]"…
>
> …references item A.7 in this Appendix.

A. Business Purpose and Foundations		
Index	**Data Reference**	**Sources, Assumptions, Methodologies**
A.1	• **Non-profit plans in Washington, D.C. are required to offer Open Enrollment**	• **Sources:** - West Group (dccode.westgroup.com), *District of Columbia Official Code §31-3514*, 2001 Edition
A.2	• **CareFirst Open Enrollment Membership in the District of Columbia**	• **Sources:** - CareFirst, enrollment data, December 2001 • **Methodologies:** - Open enrollment number given represents the number of members enrolled in open enrollment products in Washington, D.C. only
A.3	• **CareFirst's exit from Medicare+Choice and Medicaid Risk**	• **Sources:** - Accenture, interview with CareFirst executives, January 2002
A.4	• **Health Plans exiting Medicare and Medicaid**	• **Sources:** - Center for Health Care Strategies, Inc., *Transitioning Clients When Plans Exit Medicaid Managed Care Programs*, March 2001 - Managed Care On-Line (MCOL), *Medicare+Choice Plan Withdrawals*, July 25, 2000
A.5	• **In Maryland, the Health care Foundation is statutorily created**	• **Sources:** - Maryland General Assembly website (mlis.state.md.us), *Insurance code*, 2001 • **Methodologies:** - §6.5-301 States: > (a) The appropriate regulating entity shall approve an acquisition unless it finds the acquisition is not in the public interest. (b) An acquisition is not in the public interest unless appropriate steps have been taken to: (1) ensure that the value of public or charitable assets is safeguarded; (2) ensure that: (i) the fair value of the public or charitable assets of a nonprofit health service plan or a health maintenance organization will be distributed to the Maryland Health Care Foundation that was established in §20-502 of the Health- General Article… - §20-502 States: > There is a nonprofit Maryland Health Care Foundation established to promote public awareness of the need to provide more timely and cost-effective care for Marylanders without health insurance and to receive moneys that can be used to provide financial support to programs that expand access to health care services for uninsured Marylanders.
A.6	• **Missions of Foundations Created from BCBS Conversions,** possible mission of D.C. and DE foundations	• **Sources:** - Grant Makers in Health, *A Profile of New Health Foundations*, March 2001 - Health Plan press releases - Community Catalyst website - The Foundation Center website - Individual foundation websites • **Assumptions:** - Foundations created from the conversion of BCBS plans followed the *cy pres* doctrine, since all foundations resulting from converting Blues plans to date have health care as their sole mission. This is true even in states that lacked legislative requirements which dictated that foundation money must be spent on health care. - Grantmakers in Health describes the concept of the *cy pres* doctrine as follows: > **"**This trend [the transfer of assets from a non-profit foundation to another type of health organization] is supported by the *cy pres* doctrine, which supports an application of the assets to a mission as close as possible to that of the original nonprofit organization."
A.7	• **Per Capita Analysis of Foundations** Created by the	• **Sources:** - Grant Makers in Health, *A Profile of New Health Foundations*, March 2001

A. Business Purpose and Foundations			
Index	**Data Reference**	**Sources, Assumptions, Methodologies**	
	Conversion of BCBS Plans	- Health Plan press releases - Community Catalyst website - The Foundation Center website - Individual foundation websites - U.S. Census Bureau, *State and County QuickFacts*, 2000 • **Methodologies:** - Per capita foundation amount = Foundation asset amount ÷ Appropriate population > Foundation asset amount = The most recent total asset amount given for foundations created as a result of a conversion of a BCBS health plan was used. > Appropriate population = The Census Bureau provided the 2000 population data for each state where a foundation was created. ≈ For MD, DC and DE, the populations have been combined.	
A.8	• **Addition of PBO foundations could increase Annual Amount of Health Care Grants Awarded in Maryland, Delaware, and Washington, D.C. by 97%-107%**	• **Sources:** - The Foundation Center, a customized report extracted from the *Foundation Grants Index*, December 2001 • **Assumptions:** - The current annual amount of health care grants awarded in Maryland, Washington, D.C. and Delaware in 2000 is extracted from The Foundation Grants Index by The Foundation Center. The Foundation Grants Index is based on grants of $10,000 or more awarded for health organizations and health related activities by a sample of 1,015 larger foundations. The Foundation Grants Index is not inclusive of every grant awarded for health organizations and health related activities in Maryland, Delaware, and Washington, D.C., but represents one of the most comprehensive databases assembled on this subject. - The grants awarded were for health organizations and health-related activities as classified under the National Taxonomy of Exempt Entities as codes E, F, G and H. • **Methodologies:** - Percentage increase in health care grants in MD, DE, DC = CareFirst foundations potential annual grant amount ÷ Current annual grant amount > Current annual grant amount = Report showed current annual amounts awarded in Maryland ($31M), Washington, D.C ($11M) and Delaware ($18M) for a total of $61M given in the three areas. > CareFirst foundations potential annual grant amount = Range of grants that the CareFirst foundations could potentially award ($59M-$65M). See "Estimated Annual Dollar Amount Awarded by CareFirst Foundations" - The CareFirst potential annual grant amount ($59M-$65M) divided by the current annual grant amount ($61M) results in a 97%-107% increase in annual health care grants in Maryland, Delaware, and Washington, D.C. - The sum of CareFirst foundations potential annual grant amount and the current annual grant amount should equal to between $120M-$126M.	
A.9	• **Estimated Annual Dollar Amount Awarded by CareFirst Foundations and the HealthCare Georgia Foundation**	• **Sources:** - The Foundation Center, the Foundation Directory Online, 2001 - WellPoint and CareFirst, *Agreement and Plan of Merger*, November 2001 - IRS, *Handbook 7.8.3 Private Foundations Handbook*, 2001 • **Assumptions:** - The percentage of total assets spent on grants in 2000 by the largest foundations in Georgia, Maryland, Washington, D.C. and Delaware who have health care as a part of their mission can be applied to the CareFirst foundations and HealthCare GA to estimate a range of the annual amount of grants the new foundations could award. • **Methodologies:** - Percentage of total assets spent on grants by the largest foundations that	

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		include "health care" as a part of their mission = Straight and Weighted Averages of (Amount of grants given in 2000 by each foundation ÷ Amount of assets for each foundation in 2000) > Amount of grants given in 2000 by each foundation (in Maryland, Delaware, and Washington, D.C.) = Identified the five largest foundations within the Maryland, Delaware, and Washington, D.C. area that include "health care" as a part of their mission. These five foundations are listed below in order of total assets (year 2000, largest to smallest); the sum of grant monies each foundation awarded in 2000 is provided in parentheses. ≈ Morris and Gwendolyn Cafritz Foundation, DC ($13.2M) ≈ The J. Willard and Alice S. Marriott Foundation, DC ($11.1M) ≈ The Abell Foundation, MD ($12.7M) ≈ France-Merrick, MD ($11.3M) ≈ The Crystal Trust, DE ($7.1M) > Amount of grants given in 2000 by each foundation (in Georgia) = Identified the five largest foundations within Georgia that include "health care" as a part of their mission. These five foundations are listed below in order of total assets (year 2000, largest to smallest); the sum of grant monies each foundation awarded in 2000 is provided in parentheses. ≈ Robert W. Woodruff Foundation ($149.9M) ≈ Community Foundation for Greater Atlanta ($22.1M) ≈ Bradley-Turner Foundation ($20.7M) ≈ Callaway Foundation ($7.8M) ≈ Carlos and Marguerite Mason Fund ($5.5M) > Amount of assets for each foundation in 2000 = Data from The Foundation Center - The average amount of assets awarded by these foundations was 4.9%. The weighted average was 4.8%. - The IRS *Private Foundations Handbook*, Chapter 6 states that: "a private foundation must make qualifying distributions … equal to substantially all of the lesser of its: 1) adjusted net income, or 2) minimum investment return (5% of the fair market value of the foundation's assets)". This effectively means that private foundations must pay out approximately 5.0% of their assets each year (some of this 5.0% may go to administration) in order to maintain their non-profit status. - Based on the calculations above and the IRS *Private Foundations Handbook*, it is reasonable to apply 4.8-5.0% range to the $1.3B Total Assets of the CareFirst foundations and the $113M Total Assets of HealthCare Georgia. To be conservative, however, the range that was applied was 4.5-5.0%. By multiplying 4.5-5.0% by $1.3B, an estimated range of annual giving is $58.5M-$65.0M that the CareFirst foundations could donate annually to health care. The range of 4.5-5.0% was also applied to HealthCare Georgia, to arrive at an estimated range of $5.1M-$5.6M that the HealthCare GA Foundation could donate annually to health care.
A.10	• **Foundations Created by Health Plan or Hospital Conversions in CareFirst's Jurisdiction and Georgia and Their Annual Grants Awarded (2000)**	• **Sources:** - Grant Makers in Health, *A Profile of New Health Foundations*, March 2001 - The Foundation Center, *The Foundation Directory Online*, 2001 • **Assumptions**: - The data is presented by comparing the current amount of actual grants awarded by foundations created by health care conversions in each jurisdiction in 2000 and the potential grant amount if the CareFirst and HealthCare Georgia foundations were operational. Since 2001 grant data is not yet available it is not possible to compare the current amount of annual grants to the current value of the CareFirst foundations or HealthCare GA. - In one instance (Georgia Osteopathic Institute), 2000 grant data was not

Index	Data Reference	Sources, Assumptions, Methodologies
		available. In this case, we assumed they grant at the same rate as other foundations, so we applied the percentage of assets that the other foundations gave in grants to the GA Osteopathic Institute to complete the calculations. • **Methodologies:** - The foundations created by health care conversions in Maryland and Washington, D. C. are listed below with the annual amount of grants given in 2000 (to date, no foundations have been created from health care conversions in Delaware): > Consumer Health Foundation, DC ($1,100,573) > The Horizon Foundation, MD ($2,611,438) ≈ The Horizon Foundation was established in 1998 as a result of the merger of Johns Hopkins Medicine with Howard County General Hospital. Although both merging entities were non-profit organizations, and therefore, were not required by Maryland regulations to establish a foundation, the Board of Directors nonetheless decided to create The Horizon Foundation. - By adding the range of grants that the CareFirst foundations could potentially award ($59M-$65M), the new annual amount given to health care in Maryland, Delaware, and Washington, D.C. by foundations created from a conversion increases from $4M to between $63M-$69M. - The foundations created by health care conversions in Georgia are listed below with the annual amount of grants given in 2000: > Georgia Osteopathic Institute, ($136,849, estimated) > Health 1st Foundation, ($240,000) > Spaulding Health Care Trust, ($438,237) > Georgia Health Foundation, ($478,237) - By adding the range of grants that the HealthCare Georgia Foundation could potentially award ($113M x 4.5%= $5.1M and $113M x 5.0%=$5.7M), the new annual amount given to health care in GA by foundations created from a conversion increases from $1.3M to between $6.4M-$7.0M.
A.11	• **California Endowment grants in 2000**	• **Source:** - The California Endowment, *The Changing Faces of Health*, 1999-2000 (annual report) • **Methodologies:** - Percentage of assets awarded in grants = Annual amount awarded in grants ÷ California Endowment's total assets > Annual amount awarded in grants = The CA Endowment's fiscal year ended in February 2000. The foundation awarded $197M in grants during the year. > California Endowment's total assets = at the end of February 2000, the endowment's assets were valued at $3.7Billion.
A.12	• **CareFirst Funding Used to Expand the Medicaid Program**	• **Sources:** - KPMG Report to the Maryland Health Care Foundation, *Meeting Unmet Health Care Needs in Maryland: Priority Issues and Investments*, November 2001 - U.S. Census Bureau, *Current Population Reports- Health Insurance Coverage: 2000*, September 2001 - U.S. Census Bureau, *State and County QuickFacts*, 2000 • **Assumptions:** - In the report, KPMG uses an average health care insurance cost of $2,500 per capita, with 50% of this amount being subsidized by the federal government since individuals qualify for federal matching funds. Therefore, the average cost of insuring an individual who qualifies for federal matching funds is $1,250. - The $1,250 has been applied to cover individuals in Maryland, Washington, D.C. and Delaware for this analysis. - We have assumed that there are at least 52,000 individuals in the three

A. Business Purpose and Foundations			
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		jurisdictions that would qualify for federally subsidized Medicaid. • **Methodologies:** - Number of uninsured that CareFirst foundations can cover = Estimated annual amount awarded by CareFirst foundations ÷ Cost of covering one uninsured person > Estimated annual amount awarded by CareFirst foundations = $58.5M-$65.0M (see "Estimated Annual Dollar Amount Awarded by CareFirst Foundations") > Cost of covering one uninsured person = $1,250 (see assumption above regarding KPMG's use of $2,500 as the per capita average health care insurance cost) - This calculation estimates that CareFirst foundations could insure a range of 46,800 to 52,000 people through expanding the Medicaid program.	
A.13	• **Comparison of Charitable Giving By Blue Cross Blue Shield of Georgia and Blue Cross of California Pre vs. Post Conversion**	• **Sources:** - WellPoint, November 2001 - Blue Cross Blue Shield of Georgia, November 2001 • **Methodologies:** - Percentage change in charitable giving = Charitable giving post-conversion ÷ Charitable giving pre-conversion - Charitable giving post-conversion > For both companies, post-conversion years were 1996-2000 ≈ Blue Cross Blue Shield of Georgia donated on average $798,000 per year ≈ WellPoint donated on average $777,000 per year - Charitable giving pre-conversion > For both companies, pre-conversion years were 1993-1995 ≈ Blue Cross Blue Shield of Georgia donated on average $413,000 per year ≈ WellPoint donated on average $555,000 per year - BCBS GA has shown a 93% increase in post-conversion donations and WellPoint has shown a 40% increase.	
A.14	• **Percentage of Uninsured in California, Georgia and other States Where Blues Plans Have Converted**	• **Sources:** - U.S. Census Bureau, *Current Population Reports- Health Insurance Coverage: 2000*, September 2001 - U.S. Census Bureau, *Current Population Reports- Health Insurance Coverage: 1997*, September 1998 • **Assumptions:** - Blues plans in thirteen states converted to for-profit status prior to 2000 and are now operating as Anthem, Cobalt, Trigon and WellPoint. Although Anthem has announced its intent to acquire Blue Cross Blue Shield of Kansas, this sale was excluded from our analysis because Blue Cross Blue Shield of Kansas has not yet completed its conversion. - The U.S. Census Bureau added a "verification" question to its 2000 survey which produced a lower and more accurate estimate of the uninsured. Only 1998 and 1999 survey data results have been modified to reflect this change. Therefore, a trend cannot be drawn between uninsured rates reported prior to 1998. • **Methodologies:** - Definition: Compound annual growth rate (CAGR) = (Number at the end of the period ÷ Number at the beginning of the period)$^{(1 \div \text{number of years in the period})}$ - 1 - Compound annual growth rate (CAGR) of the percentage of uninsured in California, Georgia and other States where Blues plans have converted = (2000 Uninsured Rate ÷ 1998 Uninsured Rate)$^{0.5}$ - 1 > Georgia Example:	

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		≈ 2000 Uninsured Rate – 0.144 ≈ 1998 Uninsured Rate – 0.163 ≈ Divide the 2000 Uninsured Rate (.144) by the 1998 Uninsured Rate (.163) to arrive at .883. Take .883 to the power of (1/(2000-1998)) or ½. and subtract 1. Multiply this number by 100 (to turn the number into a percentage) to arrive at -6.0%. This is the rate the uninsured population has decreased in Georgia between 1998 and 2000.

B. Competition

Index	Data Reference	Sources, Assumptions, Methodologies
B.1	• **Companies licensed to transact health insurance in Maryland, Delaware, and Washington, D.C.**	• **Sources:** - InterStudy, *HMO Directory*, 11.2 edition (2000 data) - InterStudy, *PPO Directory and Performance Report*, 2.0 edition (2000 data) • **Methodologies:** - Unique is defined as insurers that have different parent companies / ownership - The number of unique HMO and PPO insurers listed in the InterStudy directories were counted within CareFirst's jurisdictions: Maryland, Delaware and Washington D.C. > Combined, there are 54 unique HMO and PPO insurers ≈ 6 insurers offer both PPO and HMO plans > There are 16 unique HMOs operating in the three CareFirst jurisdictions ≈ 4 HMOs serve members in all three CareFirst jurisdictions ≡ Aetna U.S. Healthcare ≡ CareFirst, Inc. ≡ CIGNA HealthCare ≡ Mid-Atlantic Medical Services, Inc. > There are 44 unique PPOs ≈ Approximately 60% operate in all CareFirst three jurisdictions
B.2	• **Definition of "Medical Coverage"**	• **Sources:** - CareFirst, product marketing materials, 2001 • **Methodologies:** - CareFirst defines medical coverage as members who are enrolled in individual, small group, or large group medical service products including HMO, PPO, POS, and Indemnity plans. Members enrolled in Ancillary products such as dental and vision plans only are not considered "medically covered members."
B.3	• **CareFirst market share:** CareFirst membership divided by the eligible population residing in each CareFirst jurisdiction	• **Sources:** - WellPoint, enrollment data, September 2001 - CareFirst, enrollment and population data, June 2001 utilizing: > CACI Marketing Systems' Scan / U.S. demographic software based on Census 1990 data > Employee Benefits Research Institute, *Primary Sources of Coverage*, 1999 data • **Assumptions:** > As noted below, WellPoint provided Unicare membership by state of residence. In order to match Unicare members with CareFirst jurisdictions, we had to exclude the Unicare members residing in Montgomery and Prince George counties. We assumed that total Unicare Maryland membership multiplied by the percentage eligible population in Montgomery and Prince George (as a portion of Maryland's total eligible population) would serve as a reasonable proxy for Unicare membership in these two counties. • **Methodologies:** - CareFirst membership was divided by the "eligible population" residing in each CareFirst jurisdiction. > Eligible population is defined as the population that is covered by commercial insurance and excludes the uninsured, CHAMPUS, and 65+ with traditional Medicare only ≈ Scan / U.S. software projected June 2001 population counts for each county for residents aged <65 and 65+ ≈ The *Primary Sources of Coverage* report estimated the percentage of population aged <65 and 65+ that were not covered by commercial insurance in 1999 > CareFirst Maryland is comprised of all counties except Montgomery and Prince George - these two counties border Washington, D.C. and are considered part of CareFirst's Washington, D.C. affiliate, formerly Blue Cross Blue Shield of the National Capital Area.

B. Competition		
Index	**Data Reference**	**Sources, Assumptions, Methodologies**
		> CareFirst National Capital Area is comprised of the District of Columbia, two Maryland counties, Montgomery and Prince George, as well as the following counties in northern Virginia: ≈ Alexandria, Arlington, Fairfax, Fairfax City, Falls Church, Fauquier, Frederickburg, Loudon, Manassas, Manassas Park, Prince William, Spotsylvania and Stafford > CareFirst Delaware is comprised of all counties in the state > As provided, Unicare Maryland, Delaware and the District of Columbia are each comprised of all counties in the state > Unicare Virginia membership is limited to the same counties of northern Virginia as identified for CareFirst National Capital Area - WellPoint provided us with a count of Unicare members by state of residence: Maryland, Delaware, the District of Columbia and Virginia. In order to apply the appropriate number of Unicare members to each CareFirst jurisdiction, we made the following adjustments: > First, we calculated the percentage of eligible population residing in Montgomery and Prince George counties as a portion of the total eligible population in Maryland > Second, we applied this percentage to the Unicare members identified as residing in Maryland > Next, we subtracted these members from the total Unicare members identified as residing in Maryland. The difference was added to CareFirst Maryland to determine the incremental change in market share > To determine the incremental change in market share for CareFirst National Capital area, we added the estimated Unicare members residing in Montgomery and Prince George counties (calculation outlined above) and the Unicare members identified as residing in the District of Columbia and Virginia > No adjustment was required to Unicare Delaware membership to determine the incremental change in market share for CareFirst Delaware
B.4	• **Combined market share of CareFirst's three largest competitors in the region has been increasing**	• **Sources:** - CareFirst, internal market share data, 1995- 2000 • **Methodologies:** - (See CareFirst market share, methodologies section for detail regarding how CareFirst calculates market share) - CareFirst's three largest competitors are: Aetna, Kaiser, and MAMSI. Their combined market share went from 22% in 1995 to 37% in 2000.

C. Availability and Accessibility of Doctors and Hospitals

Index	Data Reference	Sources, Assumptions, Methodologies
C.1	• **WellPoint Blue Cross of California provider contract growth**	• **Source** - WellPoint, internal contracting data, December 2001 • **Methodologies:** - WellPoint provided year-end contract counts for the 1994-2000 time period > Physician and Hospital contract counts were supplied for both the HMO and PPO product lines
C.2	• **Blue Cross Blue Shield of Georgia provider contract growth**	• **Source** - Blue Cross Blue Shield of Georgia, internal contracting data, December 2001 • **Methodologies:** - Blue Cross Blue Shield of Georgia provided contract counts as of March 30th of each year over the 1995-2001 time period > Physician, Clinician and Hospital contract counts were supplied for both the HMO and PPO product lines
C.3	• **Physician-to-Population Ratio:** The number of physicians per 100,000 residents	• **Sources:** - American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 1994 – 2002 editions - InterStudy, *HMO Industry Report*, 5.2 and 11.2 editions (1995 and 2000 data) • **Assumptions:** - There does not appear to be a correlation between the states that experienced a slower than average growth in physician-to-population ratio and those states that experienced a higher than average growth in HMO penetration from 1994-2000 > Obtained state HMO penetration data for 1994 and 2000 and compared the CAGR for each state against the CAGR of the physician-to-population ratio over the same time period • **Methodologies:** - National and state physician-to-population ratios are published annually by the American Medical Association (AMA) > The ratios are published within the Physician Trends chapter of Physician Characteristics and Distribution in the U.S. > The ratio is based on the number on non-Federal physicians in each state > The number of residents in each state is also published by the AMA and is sourced from the U.S. Census Bureau - Identified Blue Cross Blue Shield health plans that converted to for-profit status prior to 2000. The four parent Blues plans and the states that make up their operating region are listed below: > Anthem BlueCross BlueShield: Colorado, Connecticut, Indiana, Kentucky, Maine, Nevada, New Hampshire and Ohio ≈ Kansas was excluded because its conversion and merger with Anthem is still pending regulatory approval > Cobalt: Wisconsin > Trigon: Virginia > WellPoint: California, Georgia, Missouri
C.4	• **Leonard Schaeffer Comments:** Regarding WellPoint's relationship with Physicians	• **Sources:** > Company Boardroom (companyboardroom.com), audio broadcast of WellPoint and RightCHOICE Merger Conference Call, October 18, 2001 > WellPoint, *WellPoint and RightCHOICE to Merge*, October 17, 2001 (press release)
C.5	• **WellPoint appointment of a Chief Medical Officer**	• **Sources:** > WellPoint, *Dr. Woodrow Myers Joins WellPoint as Chief Medical Officer*, August 15, 2000 (press release)
C.6	• **HSCRC**: Maryland Hospital Rates are set by HSCRC	• **Sources:** - Maryland General Assembly website (mlis.state.md.us), *Insurance Code § 15-604*, 2001

C. Availability and Accessibility of Doctors and Hospitals

Index	Data Reference	Sources, Assumptions, Methodologies
		- Maryland General Assembly website (mlis.state.md.us), *Health General Code § 19-710.1.*, 2001 - Health Services Cost Review Commission (www.hscrc.state.md.us), 2001
C.7	• **Profile of multi-hospital health care systems operating in CareFirst jurisdictions**	• **Sources:** - American Hospital Association, *AHA Guide*, 2000-2001 edition - Modern Healthcare, *Hospital Systems Survey*, June 4, 2001 • **Methodologies:** - Section A of the AHA Guide provides a directory of U.S. hospitals organized by state; each hospital profile includes > Notation to indicate health care system ownership > High-level operating statistics, including utilization, expense and personnel metrics - Section B of the AHA Guide provides a directory of multi-hospital health care systems organized alphabetically - Review of the hospital / system profiles in CareFirst jurisdictions identified 15 multi-hospital health care systems - Seven of these systems had national or regional operations that extend beyond CareFirst jurisdictions: > Ascension Health based in St. Louis, MO ≈ Ranked 4th in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ System includes 44 hospitals with approx. 11,875 licensed beds ≡ 3 hospitals in MD with approx. 900 licensed beds ≡ 1 hospital in DC with approx. 550 licensed beds > Bon Secours Health System based in Marriottsville MD ≈ Ranked 32nd in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ System includes 13 hospitals with 2,975 licensed beds ≡ 1 hospital in MD with approx. 150 licensed beds > Catholic Health Initiatives based in Denver, CO ≈ Ranked 5th in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ System includes 66 hospitals with approx. 12,100 licensed beds ≡ 1 hospital in MD with approx. 375 licensed beds ≡ 1 hospital in DE with approx. 225 licensed beds > Doctors Community Healthcare Corporation based in Scottsdale, AZ ≈ System includes 6 hospitals with approx. 1,275 licensed beds ≡ 2 hospitals in DC with approx. 400 licensed beds > Sisters of Mercy of the Americas – Regional Community of Baltimore ≈ System includes 2 hospitals with approx. 425 licensed beds ≡ 1 hospital in MD with 200 licensed beds > Trinity Health based in Novi, MI ≈ Ranked 8th in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ System includes 41 hospitals with approx. 7,100 licensed beds ≡ 1 hospital in MD with approx. 450 licensed beds > Universal Health Services ≈ Ranked 21st in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ System includes 38 hospitals with approx. 5,775 licensed beds ≡ 1 hospital in DC with approx. 275 licensed beds - Eight of these systems operate solely in CareFirst jurisdictions > Adventist Healthcare based in Rockville, MD ≈ 2 hospitals in MD with approx. 550 licensed beds > Dimensions Health Corporation based in Largo, MD ≈ 2 hospitals in MD with approx. 500 licensed beds > Christiana Care Health System based in Wilmington, DE ≈ 2 hospitals in DE with approx. 875 licensed beds > Johns Hopkins based in Baltimore, MD

C. Availability and Accessibility of Doctors and Hospitals			
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		≈ Ranked 51st in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ 3 hospitals in MD with approx. 1675 licensed beds > LifeBridge Health based in Baltimore, MD ≈ Ranked 125th in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ 3 hospitals in MD with approx. 850 licensed beds > MedStar Health based in Columbia, MD ≈ Ranked 37th in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ 4 hospitals in MD with approx. 1,150 licensed beds ≈ 2 hospitals in DC with approx. 925 licensed beds > University of Maryland Medical System based in Baltimore, MD ≈ Ranked 78th in Modern Healthcare's 2001 *Hospital Systems Survey* ≈ 6 hospitals in MD with approx. 1,600 licensed beds > Upper Chesapeake Health System based in Fallston, MD ≈ 2 hospitals in MD with approx. 275 licensed beds
C.8	• **Statistics regarding distribution of hospitals in CareFirst jurisdictions by size and system affiliation**	• **Sources:** - American Hospital Association, *Hospital Statistics*, 2002 edition • **Methodologies:** - *Hospital Statistics* profiles community hospitals at the national, regional, state and MSA level - A breakdown of the total number of hospitals in each geography are provided according to eight size categories > We defined the following three categories as "small" hospitals: ≈ 6-24 beds ≈ 25-49 beds ≈ 50-99 beds > We defined the following three categories as "medium" hospitals: ≈ 100-199 beds ≈ 200-299 beds ≈ 300-399 beds > We defined the following two categories as "large" hospitals: ≈ 400-499 beds ≈ 500+ beds -
C.9	• **Blue Cross Blue Shield of Georgia Network Size has increased since merging with WellPoint**	• **Sources:** - Blue Cross Blue Shield of Georgia, internal contracting data, December 2001 • **Methodologies:** - Please see "Blue Cross Blue Shield of Georgia provider contract growth" above.

D. Medical Management Policies and Practices		
Index	**Data Reference**	**Sources, Assumptions, Methodologies**
D.1	• **Blue Cross Blue Shield of Georgia medical policy:** changes are not substantive	• **Sources:** - Accenture, interview with Blue Cross Blue Shield of Georgia executives, November 2001
D.2	• **WellPoint quote regarding its intention on medical management policy**	• **Sources:** - Accenture, interview with WellPoint executives, January 2002
D.3	• **Academic Medical Journals:** unnecessary care	• **Sources:** - Journal of the American Medical Association, Nov. 13, 1987, p. 2533-2537 - Journal of the American Medical Association, May 12, 1993, p. 2398-2402 - Journal of the American Medical Association, March 1, 1995, p. 697-701 - Pediatrics, *A community intervention trial to promote judicious antibiotic use and reduce penicillin-resistant Streptococcus pneumonia carriage in children*, p. 575-583, September 2001 - Effective Clinical Practice, *Can evidence change the rate of back surgery? A randomized trial of community-based education*, p. 95-104, May 2001 - Spine, *Coordination of primary health care for back pain. A randomized controlled trial*, p. 251-258, January 2000 - Med Care, *Reducing the cost of frequent hospital admissions for congestive heart failure: a randomized trial of a home telecare intervention*, p. 1234-1245, November 2001 - British Medical Journal, *Effects of Feedback of Information on Clinical Practice - A Review*, p. 398-402, 1991
D.4	• **WellPoint quote on disease management programs**	• **Sources:** - Accenture, interview with WellPoint executives, January 2002

E. Operations

Index	Data Reference	Sources, Assumptions, Methodologies
E.1	• **CareFirst level of customer service better than median of Blues plans**	• **Sources:** - Blue Cross Blue Shield Association, *Quarterly Survey*, 12 months through June of 2001
E.2	• **David Colby Quotes**: On merger integration	• **Sources:** - Company Boardroom (companyboardroom.com), audio broadcast of WellPoint and CareFirst BlueCross BlueShield Merger Conference Call, November 21, 2001
E.3	• **Blue Cross of California member satisfaction results**	• **Sources:** - Accenture, WellPoint member surveys, November 2001 - Marketing Leverage, focus group performed by Marketing Leverage, October 2001 - Accenture, Interviews performed by Accenture personnel with: > David Helwig, (Group President, Large Group Division, WellPoint), October 2001 > Bob Burnell, (Broker, Cassidy and Associates), October 2001 • **Methodologies:** - Current Level of Customer Satisfaction was determined through surveys. Survey was performed in Los Angeles, CA and San Francisco, CA. Members surveyed currently have health insurance coverage through WellPoint BC CA, and have maintained this coverage for six years or longer. Members also needed to be between the ages of 25 and 64. > Responses for each question were done on a scale of 1-5 (1 being Very Dissatisfied and 5 being Very Satisfied). Respondents that did not answer, or who checked an alternative box entitled "Don't know or doesn't apply" were left out of the total responses gathered for the question. For each question, responses were totaled and divided by the number of people who answered on the 1to 5 scale. The survey reflects the views of the people surveyed, and not necessarily the views of all Blue Cross of California members. - Quotes from WellPoint Blue Cross of California members were gathered from the Focus Group. Quotes from the Bob Burnell and David Helwig were gathered from one-on-one telephonic interviews performed during October 2001.
E.4	• **Merged health plans have linked customer service operations, introduced other measures to improve customer service**	• **Sources:** - Accenture, client experience
E.5	• **WellPoint intends to leverage its eCommerce work across plans**	• **Sources:** - Accenture, interview with WellPoint executive VP and General Counsel Thomas Geiser, December 2001
E.6	• **The Managed Care Handbook**: Quote on WellPoint	• **Sources:** - Peter R. Kongstvedt, *The Managed Care Handbook*, 1996

F. Products

Index	Data Reference	Sources, Assumptions, Methodologies
F.1	• **WellPoint's Individual and Small Group Enrollment:** Growth in enrollment since IPO	• **Sources:** - WellPoint, internal enrollment data, 2001 • **Assumptions:** - WellPoint Individual and Small Group enrollment numbers do not include ASO business. Hence, only WellPoint insured businesses are included. - Although partial 2001 enrollment data is available (up to September 2001), we did not use them. Enrollment is often seasonal and it is preferable to use full-year 2000 results rather than partial-year 2001 results. • **Methodologies:** - Growth in HMO enrollment = (2000 HMO membership ÷ 1992 HMO membership) – 1 - Growth in PPO enrollment = (2000 PPO membership ÷ 1992 PPO membership) - 1 - Combined growth = ((2000 HMO membership + 2000 PPO membership) ÷ (1992 HMO membership + 1992 PPO membership)) – 1 - Individual Market: > Growth in HMO enrollment = 741% > Growth in PPO enrollment = 9% ≈ According to Gartner, "BC of California is the state's largest PPO with more than 2.8 million members." – implying large incremental growth is harder. Moreover, its individual PPO membership is many times larger than its individual HMO membership. > Combined growth = 23% - Small Group Market: > Growth in HMO enrollment = 216% > Growth in PPO enrollment = 210% > Combined growth = 212%
F.2	• **David Colby Quote:** On Individual and Small Group Markets in California	• **Sources:** - Accenture, interview with WellPoint executive VP and CFO David Colby, December 2001
F.3	• **David Colby Quote:** On Individual and Small Group Markets in Georgia	• **Sources:** - Lehman Brothers, transcript of WellPoint Q2 2001 Earnings Conference Call from Lehman Brothers *WellPoint Company Update*, August 28, 2001
F.4	• **Leonard Schaeffer Quote:** On Individual and Small Group Markets in California	• **Sources:** - Lehman Brothers, transcript of WellPoint Q2 2001 Earnings Conference Call from Lehman Brothers *WellPoint Company Update*, August 28, 2001
F.5	• **Leonard Schaeffer Quote:** On Individual and Small Group Markets in Georgia	• **Sources:** - Blue Cross Blue Shield of Georgia, transcript of Form A Hearing, February 2001
F.6	• **CareFirst's Strong Presence in the Individual and Small Group (ISG) Segments**	• **Sources:** - CareFirst, internal enrollment data, 2001 • **Assumptions:** - CareFirst identifies commercial small group as employers between 1-50 employees. - CareFirst identifies the commercial individual market as those people who are less than 65 years of age, and who are not in either a Medicare or Medicaid program. • **Methodologies:** - CareFirst's market share in ISG (individual and small group) segment = CareFirst's total membership in ISG ÷ total number of members in commercial ISG products in all CareFirst jurisdictions - The commercial small group and individual market segments represent 16.4% of CareFirst's total membership as of 9/30/01. - BCBS MD and BCBS NCA membership increases for both products is reported in aggregate from 1997-2000.

F. Products		
Index	**Data Reference**	**Sources, Assumptions, Methodologies**
		> The 1997 membership number is subtracted from the 2000 membership number and divided by the 1997 membership number to arrive at a percentage increase. - The merger with BCBS of DE was not completed until 1999, and changes in reporting make it difficult to report data from BCBS prior to 1999. Therefore, BCBS DE membership increases for both products are reported separately, and represent data from 1999-2000. > The 1999 membership number is subtracted from the 2000 membership number and divided by the 1999 membership number to arrive at a percentage increase.

G. Pricing		
Index	**Data Reference**	**Sources, Assumptions, Methodologies**
G.1	• **2% premium tax**	• **Sources:** - Maryland General Assembly website (mlis.state.md.us), *Insurance Code § 6-103*, 2001 - Delaware General Assembly website (www.legis.state.de.us), Insurance Code, *§ 18-702, § 18-707*, 2001
G.2	• **Estimated CareFirst premium taxes in Maryland and Delaware**	• **Sources:** - CareFirst, internal accounting and enrollment data, January 2002
G.3	• **David Colby Quote:** On Merger Synergy and Individual and Small Group Markets	• **Sources:** - Company Boardroom (companyboardroom.com), audio broadcast of WellPoint and CareFirst BlueCross BlueShield Merger Conference Call, November 21, 2001 - Accenture, Interview with WellPoint executive VP and CFO David Colby, November 2001
G.4	• **WellPoint quote on premium price in CareFirst jurisdictions**	• **Sources:** - Accenture, interview with WellPoint executives, December 2001
G.5	• **Publicly traded health companies earnings growth projections**	• **Sources:** - FirstCall, 5-year earnings growth rate for the "Healthcare Providers" industry, January 2002 - Bloomberg, 5-year earnings growth rate for the "MED-HMO" industry, January 2002 • **Assumptions:** - Bloomberg's "MED-HMO" industry group includes a very similar list of companies as FirstCall's "Healthcare Providers". Both include WellPoint's major competitors including: Aetna Inc., Anthem Inc., United Health Group, etc.
G.6	• **WellPoint Membership Growth**	• **Sources:** - InterStudy, *The National HMO Financial Database*, 1994-2000 (data sourced from state Department of Insurance filings) • **Assumptions:** - Blue Cross of California membership figures include 125,000 members acquired through Omni Health Plan acquisition in 2000
G.7	• **Blue Cross of California Administrative Expense Savings**	• **Sources:** - InterStudy, *The National HMO Financial Database*, 1994-2000 (data sourced from state Department of Insurance filings) - Bureau of Labor Statistics, Consumer Price Index new releases, 1994-2001 • **Methodologies:** - Administrative Cost Per Member Per Month = Adjusted administrative expense ÷ Member months > Adjusted administrative expense = Administrative expense reported from 1995-2000 by Blue Cross of California were adjusted for inflation ≈ Real values were deflated by the percent change in the Consumer Price Index for All Items and within the West Urban Area from the base year of 1994 > Members months = the number of member months reported by Blue Cross of California in the appropriate year

H. Governance		
Index	**Data Reference**	**Sources, Assumptions, Methodologies**
H.1	• **WellPoint Quote**: On Health Care being locally consumed and delivered	• **Sources:** - Lehman Brothers, transcript of WellPoint Q2 2001 Earnings Conference Call from Lehman Brothers *WellPoint Company Update,* August 28, 2001 (Leonard Schaeffer quoted) - Company Boardroom (companyboardroom.com), audio broadcast of WellPoint and RightCHOICE Merger Conference Call, October 18, 2001 (Leonard Schaeffer quoted) - Blue Cross Blue Shield of Georgia, transcript of Form A Hearing, February 2001 (Leonard Schaeffer quoted)
H.2	• **Blue Cross Blue Shield of Georgia Management Changes**	• **Sources:** - Blue Cross Blue Shield of Georgia, press releases, November 2000 and March 2001 - WellPoint, press release, March 2001 - Blue Cross Blue Shield of Georgia website, Board of Directors page, 2000 - Accenture, interviews with Blue Cross Blue Shield of Georgia executives, November 2001

I. Regulation		
Index	**Data Reference**	**Sources, Assumptions, Methodologies**
I.1	• **Changes in Washington, D.C. Regulation Over Open Enrollment**	• **Sources:** - West Group (dccode.westgroup.com), *District of Columbia Official Code §31-3514*, 2001 Edition
I.2	• **Changes in Maryland Regulation Over Reserves**	• **Sources:** - Maryland General Assembly website (mlis.state.md.us), *Insurance Code § 14-117*, 2001
I.3	• **Maryland Regulators have seldom called for the distribution of reserves**	• **Sources:** - Accenture, interview with CareFirst, December 2001
I.4	• **CareFirst ranks near the middle in terms of its reserve level**	• **Sources:** - Accenture, interview with CareFirst based on reviewing BCBSA information, December 2001
I.5	• **CareFirst reserves as % of RBC**	• **Sources:** - CareFirst, reserve data, December 2001